# Patient Registration Form

**PATIENT NAME**: ______________________________________________________________________________
(first name) (middle initial) (last name)
NICKNAME: ______________________________________ DOB: ____________________SEX: ☐M ☐F
ADDRESS: _________________________________________________________________APT: ____________
CITY: _______________________________________________STATE: ____________ ZIP: ______________
HOME PHONE: _________________ DAYTIME PHONE: _________________MOBILE PHONE: ________________
SOCIAL SECURITY #:_________________________ MARITAL STATUS: ☐S ☐M ☐D ☐SEP ☐W ☐UNKNOWN

PARENT/LEGAL GUARDIAN: ____________________________________________ SSN:_____________________
ADDRESS: ______________________________________CITY:____________________STATE:______ZIP:_______
EMAIL: ________________________________________PATIENT EMPLOYER:______________________________
REFERRING PHYSICIAN:________________________________________________________________________
PCP:__________________________________________________________ PAP-__________________________
ETHNIC GROUP: ☐HISPANIC ☐NON HISPANIC ☐UNKNOWN
EMERGENCY CONTACT: ________________________________________EMERGENCY PHONE:_______________
RACE: ☐AMERICAN INDIAN/ALASKA NATIVE ☐ASIAN ☐BLACK OR AFRICAN AMERICAN
☐HAWAIIAN OR PACIFIC ISLANDER ☐WHITE
LANGUAGE: ____________________________________________

**PRIMARY INSURANCE INFORMATION** (please complete this section in full; we will copy front/back of insurance card)

INSURANCE COMPANY: ________________________________________________________________________
CLAIMS ADDRESS:____________________________________________________________________________
INSURED NAME: _____________________________________________________________________________
PATIENT RELATION: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER
INSURED DOB: _____________ INSURED ADDRESS: ________________________________________________
INSURED SEX: ☐M ☐F INSURED PHONE: __________________________________________________
INSURED EMPLOYER: _______________________________________ CELL/WORK PHONE: __________________
GRP#____________________________ID#______________________

**SECONDARY INSURANCE INFORMATION**

INSURANCE COMPANY: ________________________________________________________________________
CLAIMS ADDRESS:____________________________________________________________________________
INSURED NAME: _____________________________________________________________________________
PATIENT RELATION: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER
INSURED DOB: _____________ INSURED ADDRESS: ________________________________________________
INSURED SEX: ☐M ☐F INSURED PHONE: __________________________________________________
INSURED EMPLOYER: _______________________________________ CELL/WORK PHONE: __________________
GRP#____________________________ID#______________________

IS THIS A WORKMAN'S COMPENSATION OR MOTOR VEHICLE CLAIM? ☐YES ☐NO
DATE OF INJURY OR ACCIDENT: ____________________ IF YES, CLAIM #:_________________________________
ADJUSTER: __________________________________________ PHONE: ____________________________________
ADDRESS FOR CLAIM SUBMISSION:_____________________________________________________________
___________________________________________________________________________________________

HOW DID YOU HEAR ABOUT US? ☐PHYSICIAN ☐FRIEND ☐ADVERTISEMENT ☐OTHER____________________

PATIENT SIGNATURE: _______________________________________________________ DATE: ____________